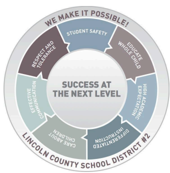

Lincoln County School District #2
360 Jefferson
Afton, WY 83110

PERMISSION FOR ADMINISTRATION OF MEDICATION AT SCHOOL AND RELEASE OF LIABILITY

An adult must bring medication to school in a pharmacy labeled container. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or instructions for administration. An adult must pick up the medication at the end of the school year, otherwise it will be discarded.

Student Information **School Year:** _____________

Name: ____ Date of Birth: _________________

School: _______________________________________ Teacher / Grade: ______________

Medication Allergies: ____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Reason for Medication: ____

Medication Name: ___________________________ Dose: ____________ Route: _______________

Time / Frequency of administration: ________________________________

If PRN, Frequency: _______________________ For Symptoms: ______________________________

Medication to be administered: Start Date:___________________ End Date:_____________________

Restrictions and/or important side effects: ▢ NONE
▢ If YES, specify:________________________________

Self Carry / Self Administration:

May self-carry: ▢ YES ▢ NO

Student is capable of appropriate and accurate self-administration: ▢ Supervised ▢ Unsupervised

Prescriber Information and Signature

Signature:____Date:___________

Name/Title:____

Telephone:________________________________ Fax:______________________________________

Address:____

TO BE COMPLETED BY PARENT / GUARDIAN

Permission from Parent / Guardian

I, _______________________________________, request and give permission for:

1. trained school personnel, to give my child (named above) the listed medication according to school board policy.
2. the school nurse to contact the health care provider named above or the pharmacist to discuss the medication and my child's health.

I agree to indemnify and hold harmless LCSD2 and its employees against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

Parent Signature:____ Date: _____________

Parent Name: ______________________________________ Phone Number: ____________________